MEDICAID FUNDED LONG-TERM CARE SERVICE AUTHORIZATION FORM

I. RECIPIENT INFORMATION:

Last Name: _____ First Name: _____ Birth Date: ___/___/_____

Social Security_____ Medicaid ID _____ Sex: _____

II. MEDICAID ELIGIBILITY INFORMATION:

Is Individual Currently Medicaid Eligible? ☐
- 1 = Yes
- 2 = Not currently Medicaid eligible, anticipated within 180 days of nursing facility admission **OR** within 45 days of application or when personal care begins.
- 3 = Not currently Medicaid eligible, not anticipated within 180 days of nursing facility admission

If no, has Individual formally applied for Medicaid? ☐
0 = No 1 = Yes

Is Individual currently Auxiliary Grant eligible? ☐
- 0 = No
- 1 = Yes, or has applied for Auxiliary Grant
- 2 = No, but is eligible for General Relief

Dept of Social Services:
(Eligibility Responsibility)_____

(Services Responsibility)_____

III. PRE-ADMISSION SCREENING INFORMATION: (to be completed only by Level I, Level II, or ALF screeners)

MEDICAID AUTHORIZATION

Level of Care ☐
- 1 = Nursing Facility Services
- 2 = PACE/LTCPHP
- 3 = AIDS/HIV Waiver Services
- 4 = Elderly or Disabled with Consumer Direction Waiver
- 11 = ALF Residential Living
- 12 = ALF Regular Assisted Living
- 14 = Individual/Family Developmental Disabilities Waiver

NOTE: Authorization for Nursing Facility or the Elderly or Disabled with Consumer Direction Waiver is interchangeable. Screening updates are not required for individuals to move between services because the alternate institutional placement is the same.

NO MEDICAID SERVICES AUTHORIZED
- 8 = Other Services Recommended
- 9 = Active Treatment for MI/MR Condition
- 0 = No other services recommended

Targeted Case Management for ALF ☐
0 = No 1 = Yes

Assessment Completed ☐
1 = Full Assessment 2 = Short Assessment

ALF provider name: _____
ALF provider number: _____
ALF admit date: _____

SERVICE AVAILABILITY ☐
- 1 = Client on waiting list for service authorized
- 2 = Desired service provider not available
- 3 = Service provider available, care to start immediately

LENGTH OF STAY (If approved for Nursing Home) ☐
- 1 = Temporary (less than 3 months)
- 2 = Temporary..(less than 6 months)
- 3 = Continuing (more than 6 months)
- 8 = Not Applicable

NOTE: Physicians may write progress notes to address the length of stay for individuals moving between Nursing Facility and the EDCD Waiver. The progress notes should provided to the local departments of social services Eligibility workers.

LEVEL I/ALF SCREENING IDENTIFICATION

Name of Level I/ALF screener agency and provider number:

1._____

2._____ ☐☐☐☐☐☐☐

☐☐☐☐☐☐☐

LEVEL II OR CSB 101B ASSESSMENT DETERMINATION

Name of Level II OR CSB Screener and ID number who have completed the Level II or 101B for a diagnosis of MI, MR, or RC.

1._____ ☐☐☐☐☐☐☐

- 0 = Not referred for Level II OR 101B assessment
- 1 = Referred, Active Treatment needed
- 2 = Referred, Active Treatment not needed
- 3 = Referred, Active Treatment needed but individual chooses NH

Did the individual expire after the PAS/ALF Screening decision but before services were received? 1 = Yes 0 = No ☐

SCREENING CERTIFICATION - This authorization is appropriate to adequately meet the individual's needs and assures that all other resources have been explored prior to Medicaid authorization for this recipient.

_____ ___/___/_____
Level I/ALF Screener **Title** **Date**

_____ ___/___/_____
Level I/ALF Screener **Title** **Date**

_____ ___/___/_____
Level I Physician **Date**

Instructions for completing the *Medicaid Funded Long-Term Care Service Authorization Form* (DMAS-96)

1. Enter Individual's Last Name. **Required.**
2. Enter Individual's First Name. **Required.**
3. Enter Individual's Birth Date in MM/DD/CCYY format. **Required.**
4. Enter Individual's Social Security Number. **Required.**
5. Enter Individual's Medicaid ID number if the Individual currently has a Medicaid card. This number should have either nine or twelve digits.
6. Sex: Enter "F" if Individual is Female or "M" if Individual is Male. **Required.**
7. Is Individual Currently Medicaid Eligible? Enter a "1" in the box if the Individual is currently Medicaid Eligible.

   Enter a "2" in the box if the Individual is not currently Medicaid Eligible, but it is anticipated that private funds will be depleted within 180 days after Nursing Home admission or within 45 days of application or when personal care begins.

   Enter a "3" in the box if the Individual is not eligible for Medicaid and it is not anticipated that private funds will be depleted within 180 days after Nursing Home admission
8. If no, has Individual formally applied for Medicaid? Formal application for Medicaid is made when the Individual or a family member has taken the required financial information to the local Eligibility Department and completed forms needed to apply for benefits. The authorization for long-term care can be made regardless of whether the Individual has been determined Medicaid-eligible, but placement may not be available until the provider is assured of the Individual's Medicaid status.
9. Is Individual currently auxiliary grant eligible? Enter appropriate code ("0", "1" or "2") in the box.
10. Dept of Social Services: The Departments of Social Services with service and eligibility responsibility may not always be the same agency. Please indicate, if known, the departments for each in the areas provided.
11. Assessment Type: Enter in the box the number that corresponds to the assessment provided. If this area is not filled in correctly, payment may not be made, may be delayed, or may be incorrect. **Required.**
12. Medicaid Authorization Enter the numeric code that corresponds to the Pre-Admission Screening Level of Care authorized. Enter only one code in this box.

NOTE: Authorization for Nursing Facility or the Elderly or Disabled With Consumer Direction Waiver is interchangeable. Screening updates are not required for individuals to move between services because the alternate institutional placement is the same.

1 = **NURSING FACILITY** authorize only if Individual meets the Nursing Facility (NF) criteria and community-based care is not an option.

2 = **PACE/LTC PREPAID HEALTH PLAN** authorize only if Individual meets NF criteria (pre-NF criteria does not qualify) and requires a community-based service to prevent institutionalization.

3 = **HIV/AIDS WAIVER** authorize only if Individual meets the criteria for AIDS/HIV Waiver services and requires AIDS/HIV Waiver services to prevent institutionalization (that is, case management, private duty nursing, personal/respite care, nutritional supplements).

4 = **ELDERLY OR DISABLED WITH CONSUMER DIRECTION WAIVER** authorize only if Individual meets NF criteria and requires a community-based service to prevent institutionalization.

11 = **ALF RESIDENTIAL LIVING** authorize only if Individual has dependency in either 1 ADL, 1 IADL or medication administration.

12 = **ALF REGULAR ASSISTED LIVING** authorize only if Individual has dependency in either 2 ADLs or behavior.

14 = **Individual/Family Developmental Disabilities** authorize only if the Individual meets the criteria for admission into an ICF/MR facility and meets the Level of Functioning screening criteria.

If ALF is authorized, enter, if known, in item 29, the provider number of the ALF that will admit the Individual. Enter, in item 27, the date the Individual will be admitted to that ALF.

0 = **NO OTHER SERVICES RECOMMENDED** use when the screening team recommends no services or the Individual refuses services.

12. 8 = **OTHER SERVICES RECOMMENDED** includes informal social support systems or any service excluding Medicaid-funded long-term care (such as companion services, meals on wheels, MR waiver, rehab. services, etc.)

    9 = **ACTIVE TREATMENT FOR MI/MR CONDITION** applies to those Individuals who meet Nursing Facility Level of Care but require active treatment for a condition of mental illness or mental retardation and cannot appropriately receive such treatment in a Nursing Facility.
13. Targeted Case Management for ALF ***If ARC, ARR or ARI is authorized***, you must indicate whether Targeted Case Management for ALF (quarterly visits) are also being authorized. The Individual must require coordination of multiple services and the ALF or other support must not be available to assist in the coordination/access of these services. Enter a "0" if only the annual reassessment is required.
14. Service Availability If a Medicaid-funded long-term care service is authorized, indicate whether there is a waiting list (#1) or that there is no available provider (#2), or whether the service can be started immediately (#3).
15. ALF Reassessment: If this is an ALF Reassessment enter the appropriate code for No or Yes. Then mark the appropriate box for a short reassessment or a long reassessment.
16. Length of Stay If approval of Nursing Facility care is made, please indicate how long it is felt that these services will be needed by the Individual. The physician's signature certifies expected length of stay as well as Level of Care.

    NOTE: Physicians may write progress notes to address the length of stay for individuals moving between Nursing Facility or the EDCD Waiver. The progress notes should provided to the local departments of social services Eligibility workers.
17. Level I/ALF Screening Identification Enter the name of the Level I screening
& agency or facility (for example, Hospital, local DSS, local Health, Area Agency
18. on Aging, CSB, State MH/MR facility, CIL) and below it, in the 11 boxes provided, that entity's 8-digit provider ID and 3-digit location code.

    For Medicaid to make prompt payments to Pre-Admission Screening committees, all of the information in this section must be completed. *Failure to complete any part of this section will delay reimbursement.*
19. If the screening is a Nursing Home Pre-Admission Screening completed in the
& locality, there should be two Level I screeners, both the local DSS and local
20. Health departments. Otherwise, there will only be one Level I screener identification entered.
    Do NOT fill in Lines 16 and 17 or lines 18 and 19 if lines 20 and 21 are filled in. Submit a separate DMAS-96 form.
21. Level II Assessment Determination If a Level II assessment was performed (MI,
& MR or Dual), enter the name of the assessor on line 20 and the provider number
22. on line 21. *Do NOT fill in line 20 and 21 if lines 16 and 17 are also filled in*. Submit a separate DMAS-96 form.
23. Enter the appropriate code in the box.
24. When a Screening Committee is aware that an Individual has expired prior to receiving the services authorized by the screening committee, a "1" should be entered in this box.
25. The Level I/ALF Screener must sign and date the form. **Required.**
26. The Level I/ALF Screener must sign and date the form. **Required for all services except ALF placement.**
27. The Level I physician must sign and date the form. **Required for all services except ALF placement.**
28. Enter the date the Individual entered an ALF. Otherwise leave blank. If the Level of Care authorized is NFS, give a copy of this form to the Nursing Facility. The Nursing Facility must enter the date Medicaid Care of the Individual began in this space and place a copy of the form ON TOP of their admission packet.
29. Enter the name of the ALF in which the Individual was placed. Otherwise leave blank. If the Level of Care authorized is NFS, give a copy of this form to the Nursing Facility. The Nursing Facility must enter their name in this space and place a copy of the form ON TOP of their admission packet.
30. Enter the provider number of the ALF in which the Individual was placed. Otherwise leave blank. If the Level of Care authorized is NFS, give a copy of this form to the Nursing Facility. The Nursing Facility must enter their provider number in this space and place a copy of the form ON TOP of their admission packet.